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Supreme Court, U.S.
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No. 05-1386

IN THE

Supreme Court of the United States

KATHLEEN SEMIEN,
Petitioner,

v.

LIFE INSURANCE COMPANY OF NORTH AMERICA, A CIGNA COMPANY, AND BP LONG TERM DISABILITY (LTD) PLAN,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

BRIEF IN OPPOSITION

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QUESTION PRESENTED

The employee benefit plan in which petitioner is a member provides its administrator with discretion in determining eligibility for benefits. The claims administrator in this case reviewed petitioner's medical file (which included numerous statements of petitioner's own physicians indicating she was able to return to work in light or reduced capacities) and consulted with two independent medical professionals and an occupational health specialist, all three of whom also reviewed petitioner's file. Based on its review of the claim record, the administrator denied petitioner's claim for an extended long-term disability benefit.

In a subsequent judicial challenge, both courts below held that petitioner failed to point to anything in the claim record before the administrator demonstrating that its benefit determination was arbitrary or capricious. Indeed, the district court held that, even if review of the administrator's decision had been *de novo*, the court would have upheld the benefit denial.

The question properly presented is:

Whether this Court should grant certiorari to review the decisions below holding that petitioner failed to demonstrate that the administrator's benefit determination was arbitrary and capricious, where (a) the decisions below apply settled legal rules and implicate no circuit conflict, (b) both courts found that that, on the particular facts of this case, petitioner was not entitled to discovery beyond the record presented to the administrator, and (c) the district court held that it would have rejected petitioner's benefit claim even on *de novo* review.

RULE 29.6 STATEMENT

Respondent Life Insurance Company of North America is owned by Connecticut General Corporation, which is owned by Cigna Holding, Inc., which is owned by CIGNA Corporation. Respondent BP Long Term Disability (LTD) Benefit Plan is not a corporation.

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INTRODUCTION

In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), this Court held that when an employee benefit plan vests the plan administrator with discretion to interpret and enforce the plan, the administrator's benefit determination is reviewed in a subsequent challenge under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), only for abuse of discretion, and must be upheld under that standard unless it is found to be arbitrary and capricious. 489 U.S. at 110-11. In the wake of *Firestone*, every federal circuit has held that such arbitrary and capricious review is to be conducted on the basis of the claims record presented to the administrator. *See infra* at 11-12. Applying those settled principles here, both courts below held that petitioner failed to point to anything in the claim record before the administrator demonstrating that the denial of petitioner's claim to an extended long-term disability benefit was arbitrary and capricious.

Nothing about this case warrants review by this Court. The district court's judgment is a straightforward, factbound application of firmly settled law governing the adjudication of benefit claims under ERISA § 502(a)(1)(B). The Seventh Circuit's affirmance of that judgment does not conflict with any decision of this Court or of any other circuit. The petition's contrary suggestion simply reflects a misunderstanding of both the decision below and the substantive legal standards governing that decision. Finally, a decision by this Court will have no effect on the disposition of this case, because the most petitioner seeks is more searching judicial scrutiny of the administrator's benefit determination, and the district court has *already* held that even under a *de novo* standard, the denial of petitioner's request for benefits would stand. Accordingly, any decision by this Court would be at best advisory in this case.

This case is, in short, a most unworthy candidate for certiorari. The petition should be denied.

STATEMENT OF THE CASE

This case arises out of a claim for long-term disability ("LTD") benefits that petitioner Kathleen Semien filed after leaving her job at BP Amoco ("BP"). Petitioner received LTD benefits for an initial two-year period, but at the end of that period respondent Life Insurance Company of North America ("LINA") determined that she did not meet the qualifications for a second, extended LTD benefit under the terms of the benefit plan LINA administered. Petitioner pursued her internal plan appeals and then sued under ERISA, seeking an order establishing her entitlement to the extended LTD benefit. Both the district court and the Seventh Circuit rejected her claim. This petition followed.

A. Factual Background

1. Petitioner began working for BP in February 1989 as an environmental remediation manager. Pet. App. 2a. She was employed as a chemical engineer when she left BP on May 15, 2000. *Id.*

2. BP sponsored a Consolidated Welfare Benefits Plan ("the Plan") that provided LTD benefits to eligible employees. *Id.* LINA functioned as the claims administrator for the plan pursuant to an administrative services agreement with BP. *Id.* at 2a-3a. Under that agreement, LINA was responsible for processing claims for benefits under the Plan, including the ultimate determination whether a claim satisfied the Plan's requirements for payment of benefits. *Id.* at 3a. LINA also insured the benefits provided through the Plan. *Id.*

Under the terms of the Plan, a participant was entitled to receive LTD benefits for 24 months upon a showing that she "could not perform her 'Regular Occupation or a Qualified Alternative.'" *Id.* "After the initial 24-month period, a more stringent standard applied." *Id.* A participant was eligible for an extended LTD benefit if, "solely because of Injury or

Sickness," she was (1) unable to perform all the material duties of any occupation for which she was or could reasonably become qualified or (2) unable to earn 80% or more of her prior earnings. *Id.* at 4a-5a.

The Plan also conferred on the administrator complete discretionary authority over the administration of plan benefits, including final benefit determinations:

> The plan administrator (or his authorized delegates) has full and exclusive authority and discretion to:
>
> ◦ determine the eligibility of any individual to participate in and receive plan benefits; and
>
> ◦ grant and deny claims under the plan, including the power to interpret the plans.

Id. at 31a.

3. Petitioner made her initial claim for LTD benefits in September 2000, four months after leaving BP. *Id.* at 3a. She claimed that she suffered from a number of medical conditions, including back pain, a herniated lumbar disk, bone spurs in her neck, carpal tunnel syndrome, problems in her joints and extremities, fibromyalgia, and past sickness as a result of Hepatitis C. *Id.* She also asserted that she suffered from chronic depression, suicidal thoughts, and mental confusion. *Id.*

LINA approved petitioner's initial claim for LTD benefits in November 2000, on the grounds that she was suffering from side effects from hepatitis C, medication, fatigue, and pain, and thus could not perform her regular occupation or a qualified alternative. *Id.* LINA stated, however, that it would continue to monitor petitioner's condition and request additional medical records on an ongoing basis to ensure eligibility. *Id.* Further, LINA approved petitioner's claim only for the initial 24-month benefit period. *Id.*

During the two-year initial period, petitioner submitted additional medical documentation to LINA, including assessments performed by her own physicians. *Id.* at 3a-4a. Most of those assessments stated that petitioner was capable of performing moderate work, even though her abilities were limited. *Id.* at 4a; *see also* Resp. C.A. Br. 4-8 (collecting record cites).

By the end of the two-year initial period, most of petitioner's doctors had concluded that she was able to return to work. "Drs. Te, Fintel, and Ruderman (a hepatologist, gastroenterologist, and rheumatologist, respectively) each gave the go-ahead for Semien to return to work." Pet. App. 22a. One of her psychiatrists, Dr. Skerchock, "concluded that Semien could perform within an adequate range of performance" and "expected that Semien's condition would stabilize through further treatment and medication." *Id.* Dr. Skerchock's treatment notes indicated that petitioner repeatedly stated her desire to return to work. D. Ct. Dkt. #20, at 24-27; Dkt. #25, ¶ 35. Another psychiatrist, Dr. Koziol, "noted that Semien had clear improvement in her energy level and planned to return to work." Pet. App. 22a. Dr. Betman, petitioner's primary care physician, stated that she "could gradually return to work." *Id.*[1] Only Dr. Liu, who had performed surgery on petitioner's back in January 2002, suggested that she should not return to work because of her "continuing pain" and "need for narcotic medication." *Id.* at 22a-23a.

4. As the November 2002 end of the initial benefit period approached, the medical information submitted by petitioner to LINA was reviewed by a Nurse Care Manager and a Behavior Care Specialist. *Id.* at 4a. In a letter dated No-

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[1] After LINA reviewed petitioner's eligibility for continued benefits and determined that she was no longer eligible, however, "Dr. Skerchock wrote a letter to Dr. Betman stating that Semien was not employable at all," and Dr. Betman wrote a letter stating that she was "unable to sustain full time employment." Pet. App. 23a.

vember 22, 2002, LINA notified petitioner that the medical information she had provided did not establish her qualification for the extended LTD benefit. *Id.* (quoting letter stating that "the medical documentation does not support your inability to perform your occupation as an Environmental Business Manager").

5. Petitioner filed an internal appeal of the denial of benefits. *Id.* at 5a. To review her appeal, LINA retained several independent experts, including an independent psychiatrist, Dr. Jack Greener; an independent physician, Dr. Eddie Sassoon; and an independent senior rehabilitation counselor and vocational expert, Lynne Lonberg. *Id.* at 5a-6a.

"Both doctors concluded that, although Semien could not return to her former employment, there were jobs within her field not precluded by her medical limitations." *Id.* at 23a. Dr. Greener reviewed petitioner's medical records and concluded in a detailed fourteen-page report that she had moderate to severe depression but that she would be able to perform a sedentary to light job that did not have irregular or unplanned hours, emergency situations, or travel. *Id.* at 5a. Dr. Sassoon separately reviewed petitioner's records and independently concluded that she was capable of performing a sedentary or light duty occupation. *Id.* Lonberg conducted a "Transferable Skills Analysis" based on the reports of Dr. Greener and Dr. Sassoon and determined that there were several occupations that petitioner could perform based on her education, skills, and physical and mental abilities, including working as a chemical engineer, a chemical research engineer, or an adsorption and absorption engineer. *Id.* at 6a.

On June 27, 2003, on the basis of the independent doctors' reports and the vocational skills assessment, LINA affirmed the initial determination that petitioner did not qualify for LTD benefits under the Plan terms applicable after the initial 24-month period. *Id.*

B. Proceedings Below

1. Petitioner filed suit in federal district court under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), seeking an order requiring the Plan and LINA to provide her the Plan's extended LTD benefit. Pet. App. 6a.

2. In proceedings before the district court, petitioner sought discovery from LINA on a variety of matters. Pet. App. 6a. In response LINA provided petitioner with the entire administrative record, but objected to discovery beyond the scope of that record, including discovery into the relationship between LINA and the physicians it consulted. *Id.* The district court denied petitioner's motion to compel discovery into these matters. *Id.* at 31a-33a.

The district court's discovery opinion first notes that because the Plan gave LINA "discretionary authority to determine whether beneficiaries such as Semien are entitled to disability benefits," LINA's benefit determination would be reviewed under the deferential "arbitrary and capricious" standard of review, consistent with this Court's decision in *Firestone*. *Id.* at 31a. The opinion further notes that while "a plan administrator's self-interest is a factor to weigh in evaluating the plan's decision," discovery into defects or bias in the decisionmaking process is not automatic, but requires some threshold "indication of impropriety." *Id.* at 32a; *see id.* (discovery into bias is not appropriate when "there can be no doubt that the application was given a genuine evaluation" by the plan (internal quotation marks omitted)). Because petitioner "offer[ed] no indication, other than the fact[] [that] LINA's consultants are paid for their services, that Semien's decision-makers would be biased against her," petitioner's request for material exceeding the scope of the claims record was denied. *Id.* at 33a. Accordingly, the court limited the trial record to the "materials that were before the plan administrators when they reached their decision." *Id.* at 32a.

The parties subsequently filed cross-motions for summary judgment. The district court entered summary judgment for LINA and the Plan, upholding LINA's determination that petitioner no longer qualified for disability benefits. The court first reviewed the medical evidence submitted by petitioner. The court noted that, by the end of her initial two-year benefit period, most of her doctors, including her primary care physician, had determined that she could return to work. Pet. App. 22a-23a.

The district court again noted that arbitrary and capricious review applied because "the plan documents afford discretion to the plan administrator to determine benefit eligibility and specifically invoke the arbitrary and capricious standard." Pet. App. 26a. The court then reviewed the undisputed medical evidence in the record and determined that "it supports, without straining, a conclusion that Semien was capable of performing occupations for which she was qualified as of November 2002." *Id.* at 27a. It noted that although there were some "conflicting opinions" among petitioner's various doctors, "two separate experts" reviewed all of those opinions and came to the same conclusion, which was that "Semien was not prevented from returning to a job suitable to her experience and training by her physical or psychiatric limitation." *Id.* "Three specific occupations, one of which she had already performed, were identified as being amenable to her situation." *Id.* Thus, there was "no basis to overturn the denial of Semien's benefits." *Id.*

Importantly, the district court noted that petitioner would not be entitled to relief *even under de novo review*:

> [I]n the circumstance of this case, the denial of benefits would survive even if we applied the de novo standard. The medical opinions given by Semien's treating physicians on her myriad conditions are inconsistent at best and contradictory at worst, with some of her doctors even disagreeing with their own diagnoses in the space of as

> little as two weeks. The concurrence of both independent experts, who examined the medical evidence as a whole, leads us to agree that a denial of benefits was appropriate, even under the more relaxed standard.

Id. at 27a n.6.

3. A unanimous panel of the Seventh Circuit affirmed, in an opinion by Judge Flaum (joined by Judge Bauer and Judge Evans). The court of appeals first confirmed that LINA's denial of benefits was properly reviewed under the arbitrary and capricious standard, rather than *de novo*, because the Plan and administrative services agreement "clearly and unequivocally" granted discretion to LINA as the claims administrator. Pet. App. 7a (quoting *Perugini-Christen v. Homestead Mortgage Co.*, 287 F.3d 624, 626 (7th Cir. 2002)).

Applying the arbitrary and capricious standard, the court of appeals determined that, construing all facts in the summary judgment record in favor of petitioner, there was no basis for overturning LINA's decision. Pet. App. 11a. The court noted that the physicians LINA consulted gave "thorough consideration" to all of the evidence that Semien submitted and concluded that she was capable of performing certain jobs. *Id.* at 12a. Although some of petitioner's doctors reached different conclusions, there was "no evidence in the record" suggesting that the independent physicians were biased or that their appraisals were "so inherently flawed as to be rendered arbitrary and capricious." *Id.* at 13a.

The court of appeals also addressed petitioner's claim that she was entitled to further discovery regarding the relationship between LINA and the physicians it consulted. The court noted that it is "reluctan[t] to grant extensive discovery in ERISA cases" where "'there can be no doubt that the application [for benefits] was given a genuine evaluation.'" Pet. App. 14a (quoting *Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan*, 195 F.3d 975, 982 (7th Cir.

2000)). But the court recognized that when an administrator's "impartiality can fairly be questioned, district courts should allow limited discovery." Pet. App. 15a-16a (internal quotation marks omitted). The purpose of that discovery is to "ensure that . . . conflicts of interest have not contributed to an unjustifiable denial of benefits." *Id.* at 17a.

The Seventh Circuit explained the particular circumstances that could justify limited discovery: "Where a claimant makes specific factual allegations of misconduct or bias in a plan administrator's review procedures, limited discovery is appropriate." *Id.* A claimant must (1) "identify a specific conflict of interest or instance of misconduct" and (2) "make a prima facie showing that there is good cause to believe limited discovery will reveal a procedural defect in the plan administrator's decision." *Id.* In this case, however, petitioner "presented no prima facie evidence of misconduct or conflict of interest," and thus the court of appeals affirmed the denial of her motion to compel discovery. *Id.* at 19a.

REASONS FOR DENYING THE PETITION

Petitioner seeks certiorari to address a single question, *viz.*, whether "the Article III powers of a district court in adjudicating a civil action [under ERISA § 502(a)(1)(B)] are limited to conducting a review proceeding." Pet. i. Petitioner's Question Presented reveals a basic misunderstanding of the settled law governing § 502(a)(1)(B) actions. Properly understood, the issue petitioner is attempting to raise was squarely answered by this Court in *Firestone*, a decision followed faithfully in this case by the courts below. Nothing about the trial court's factbound application of deferential review under *Firestone*, or the Seventh Circuit's affirmance of that judgment, warrants review by this Court.

A. The Review Standard Applied Below Is Perfectly Consistent With This Court's Precedents And Implicates No Circuit Conflict

Petitioner's central argument is that the decision below conflicts with ERISA's text and legislative history, and with an opinion of this Court involving Title VII, simply because the opinion analogizes a judicial action under ERISA § 502(a)(1)(B) to an administrative "review proceeding." Pet. 10. According to petitioner, ERISA authorizes "a plenary court proceeding" in all § 502(a)(1)(B) challenges, and thus the trial record cannot be limited to the claims record presented to the administrator. *Id.*

Petitioner is wrong. Equally important, her contention raises no issues that are the subject of legal controversy in the circuits.

1. *The Decisions Below Follow This Court's Decision In* Firestone *And Uniformly Recognized Principles Of Arbitrary And Capricious Review*

ERISA § 502(a)(1)(B) creates a federal civil action "to recover benefits due . . . under the terms" of an ERISA-governed employee benefit plan. 29 U.S.C. § 1132(a)(1)(B). This Court held in *Firestone*, however, that where – as here – the plan confers discretion on the plan administrator, the administrator's benefit determination is subject to review in a § 502(a)(1)(B) action only for abuse of discretion, and will be set aside under that standard only if shown to be arbitrary and capricious. 489 U.S. at 110-11. According to this Court, that rule follows directly from the statute itself: ERISA codifies "certain principles developed in . . . the law of trusts," and "[t]rust principles make a deferential standard of review appropriate when a trustee exercises discretionary powers." *Id.* (internal quotation marks omitted). The substantive review standard applied in a § 502(a)(1)(B) is thus plainly not "plenary" – it is the most deferential standard that can be applied in a judicial proceeding. *See Williams v. Int'l*

Paper Co., 227 F.3d 706, 712 (6th Cir. 2000) ("the arbitrary and capricious standard is the least demanding form of judicial review").[2]

Further, *every* federal circuit agrees with the decision below that, in adjudicating a § 502(a)(1)(B) challenge subject to the deferential arbitrary and capricious review standard, the district court should limit itself to reviewing the same claim record presented to the plan administrator. "The ordinary rule is that review for arbitrariness is on the record made before the entity being reviewed." *Liston v. UNUM Corp. Officer Severance Plan*, 330 F.3d 19, 23 (1st Cir. 2003); *see Miller v. United Welfare Fund*, 72 F.3d 1066, 1071 (2d Cir. 1995); *Mitchell v. Eastman Kodak Co.*, 113 F.3d 433, 440 (3d Cir. 1997); *Elliott v. Sara Lee Corp.*, 190 F.3d 601, 608 (4th Cir. 1999); *Vega v. Nat'l Life Ins. Servs.*, 188 F.3d 287, 300 (5th Cir. 1999); *Univ. Hosps. of Clev. v. Emerson Elec. Co.*, 202 F.3d 839, 848 n.7 (6th Cir. 2000); *Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan*, 195 F.3d 975, 981-82 (7th Cir. 1999); *Cash v. Wal-Mart Group Health Plan*, 107 F.3d 637, 641 (8th Cir. 1997); *Taft v. Equitable Life Assurance Soc'y*, 9 F.3d 1469, 1471 (9th Cir. 1993); *Sandoval v. Aetna Life & Cas. Ins. Co.*, 967 F.2d 377, 380 (10th Cir. 1992); *Lee v. Blue Cross/Blue Shield of Ala.*, 10 F.3d 1547, 1550 (11th Cir. 1994); *Block v. Pitney Bowes, Inc.*, 952 F.2d 1450, 1455 (D.C. Cir. 1992). This rule rests on the sound principle that "[p]ermitting a district court to examine evidence outside the administrative record would open the door to the anomalous conclusion that a plan administrator abused its discretion by failing to con-

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[2] The federal courts of appeal have labeled the standard of review when a plan administrator has discretionary authority both "abuse of discretion" review and "arbitrary and capricious" review. *Block v. Pitney Bowes Inc.*, 952 F.2d 1450, 1454 (D.C. Cir. 1992). "The distinction, if any, between 'arbitrary and capricious review' and review for 'abuse of discretion' is subtle." *Id.* Because the Seventh Circuit generally refers to "arbitrary and capricious" review, this brief does the same.

sider evidence not before it." *Taft*, 9 F.3d at 1472; *see Liston*, 330 F.3d at 23-24 ("[H]ow could an administrator act unreasonably by ignoring information never presented to it?"). The general rule also "keep[s] district courts from becoming substitute plan administrators." *Cash*, 107 F.3d at 641-62 (internal quotation marks omitted). In short, so long as the administrator's decision is within the range of conclusions permissible on the basis of the record before it, the decision cannot be deemed arbitrary and capricious. *See Zervos v. Verizon N.Y., Inc.*, 252 F.3d 163, 168-69 (2d Cir. 2001) ("discretion" means decisionmaker has authority "to make a decision – of its choosing – that falls within a range of permissible decisions").[3]

The courts – including the Seventh Circuit – also recognize that district courts adjudicating challenges under the arbitrary and capricious review standard must actually review the evidence that was before the plan administrator. As the Sixth Circuit opinion quoted by petitioner correctly observes, arbitrary and capricious review "inherently includes some review of the quality and quantity of the medical evidence and the opinions on both sides of the issue." Pet. 17 (quoting *McDonald v. W.-S. Life Ins. Co.*, 347 F.3d 161, 172 (6th Cir. 2003)). But this means only that the court must "review *the administrative record*," 347 F.3d at 172 (emphasis added) – not conduct a *de novo* factfinding proceeding ranging beyond the claims record actually submitted to the administra-

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[3] None of the circuits has held, however, that there is an *absolute* bar to discovery when the plan administrator's determination is reviewed under the arbitrary and capricious standard. *E.g.*, *Liston*, 330 F.3d at 23 ("we have declined . . . to adopt an ironclad rule against new evidence"). The courts of appeal have instead described a variety of circumstances in which district courts may consider evidence beyond the administrative record, such as when "the decision process is too informal to provide a record," *id.* at 23; when external evidence is required to "interpret[] the plan or explain[] medical terms and procedures relating to the claim," *Vega*, 188 F.3d at 299; or when the administrator apparently did not conduct a "genuine evaluation," *Perlman*, 195 F.3d at 982.

tor. This Court made precisely the same point in another decision cited by petitioner, *Motor Vehicle Manufacturers Ass'n v. State Farm Mutual Automobile Insurance Co.*, 463 U.S. 29 (1983), which holds that an agency's decision is deemed arbitrary and capricious if it lacks a reasoned and logical connection to the *facts and evidence before the agency*. *Id.* at 43.

The decisions below adhere faithfully to these standard principles of arbitrary and capricious review. The district court's opinion details at length the medical information submitted to the claims administrator. Pet. App. 21a-23a. Analyzing that information, the opinion specifically describes the conflicting views of petitioner's own doctors, as well as the consistent views of the independent professionals who reviewed her file. *Id.* at 27a & n.6. The court of appeals' opinion likewise describes all the evidence in the claims record, including both the statements of petitioner's doctors and the conclusions of the independent consulting professionals, *id.* at 3a-6a, and concludes that nothing in that record establishes that LINA's decision denying her eligibility for extended LTD benefits was arbitrary and capricious, *id.* at 13a. In no respect do the factbound decisions below conflict with any decision of this Court or of any other circuit addressing the basic standards governing review of discretionary benefit determinations in § 502(a)(1)(B) actions.

2. *The Decision Below Does Not "Exempt" ERISA Actions From The Rules Of Procedure Generally Governing All "Civil Actions"*

The foregoing discussion also refutes petitioner's absurd contention that the decision below "exempts ERISA cases from the Federal Rules of Civil Procedure" (Pet. 18) in favor of a "quasi-administrative law" scheme (*id.* at 21). *See also* AARP Br. 5-6, 9. Petitioner's contention rests entirely on the fact that courts adjudicating *discretionary* benefit determinations provide only limited, arbitrary and capricious re-

view. As just explained, however, that review standard is mandated by this Court's decision in *Firestone* and by the trust principles underlying ERISA. Further, there is no tension between following the *procedural* rules applicable to any civil action and adjudicating an action according to the *substantive* rule of review mandated by *Firestone*. This case illustrates the point: the trial court's summary judgment order was the product of a standard civil action governed by the Federal Rules, with discovery into matters relevant in this type of action, i.e., discovery of the entire administrative claims record. Neither decision below suggests in any way that these actions were "exempt" from the Federal Rules.

There is thus plainly no conflict between the decision below and the various decisions cited by petitioner holding that courts must provide full, *de novo* review in civil actions arising under *other* statutes. The principal case petitioner cites, *Chandler v. Roudebush*, 425 U.S. 840 (1976), holds that claims brought under Title VII must be considered *de novo* by the district court, even when there has been a prior administrative proceeding. *Id.* at 845. But that simply is not the substantive rule governing this proceeding: as already discussed, this case is controlled by *Firestone*, which holds that ERISA § 502(a)(1)(B) challenges are *not* reviewed *de novo* where – as here – the administrator has discretion.

New Hampshire Fire Insurance Co. v. Scanlon, 362 U.S. 404 (1960), is even farther afield. That case simply holds that tax levy cases must be treated as "civil actions" governed by the Federal Rules. *Id.* at 406. As noted, the proceedings in this case *were* governed by the Federal Rules, even while the substantive rule of decision was dictated by the terms of the Plan and by *Firestone*.

Richardson v. Perales, 402 U.S. 389 (1971), likewise has nothing to do with this case. *Richardson* involves the quantum of evidence required in an administrative proceeding for benefits under the Social Security Act – not the judicial stan-

dard of review applicable to a discretionary benefit determination made by the administrator of a private employee benefit plan. This Court has specifically recognized the "critical differences between the Social Security disability program and ERISA benefit plans" that "caution against" importing rules "from the former area into the latter." *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 832-33 (2003). Petitioner herself notes the distinction. Pet. 22. And this Court in *Firestone* settled the rule applicable to review of an ERISA plan's discretionary benefit determination: so long as the administrator's decision is not arbitrary and capricious – that is, so long as the decision reflects a rational conclusion from the claims record – it must be upheld. *See supra* at 10-13. The rules applicable to a Social Security proceeding have no relevance here.

Petitioner also asserts a conflict with *Nord* (Pet. 23), but that decision, if anything, strongly *supports* the decision below. *Nord* holds that a plan administrator is not required to give special weight to the opinion of a claimant's treating physician as to the claimant's disability. 538 U.S. at 834. In so doing *Nord* applies the basic rule of arbitrary and capricious review that so long as the decisionmaker's judgment finds support in claims record evidence reasonably deemed reliable, the decision must be upheld by a reviewing court. *Id.* Both courts in this case properly applied that standard.

3. *The Decision Below Implicates No Conflict Over The Standard For Discovery Into A Benefit Plan Decisionmaker's Alleged Bias*

Finally, there is also no conflict over the standard applicable to requests for discovery into whether or not the benefit determination was affected by bias on the part of the decisionmaker. Pet. 18-20. According to petitioner, "the Seventh Circuit stands alone" in respect to discovery into potential bias. *Id.* at 19. Not so.

To start, the circuit-court opinions that have mentioned this issue all agree that bias or corruption may sometimes be a relevant area of inquiry outside the claims record. *See Liston*, 330 F.3d at 23; *Zervos v. Verizon N.Y., Inc.*, 252 F.3d 163, 174 (2d Cir. 2001); *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 395 (3d Cir. 2000); *Calvert v. Firstar Fin., Inc.*, 409 F.3d 286, 293 n.2 (6th Cir. 2005); *Farley v. Ark. Blue Cross & Blue Shield*, 147 F.3d 774, 776 n.4 (8th Cir. 1998); *Abatie v. Alta Health & Life Ins. Co.*, 2006 U.S. App. Lexis 20829, at *36 (9th Cir. 2006). And even those comments appear only in dicta – there are no square holdings on this issue in any other circuit (i.e., no published decisions reversing or affirming a district court decision on whether to allow such discovery). There is thus no conflict in legal standards justifying certiorari. *See* Robert L. Stern et al., *Supreme Court Practice* 225 (8th ed. 2002) ("there must be a real or 'intolerable' conflict on the same matter of law or fact, not merely an inconsistency in dicta or in the general principles utilized").

What is more, none of the foregoing decisions establishes that discovery into bias is automatic every time a plaintiff seeks it. As in all discovery matters, a district court considering a request for discovery into bias "is to be guided by its sound discretion." *Tremain v. Bell Indus.*, 196 F.3d 970, 978 (9th Cir. 1999); *see also Kosiba v. Merck & Co.*, 384 F.3d 58, 67 n.5 (3d Cir. 2004), *cert. denied*, 544 U.S. 1044 (2005). The few decisions that have squarely addressed district court holdings on the issue have held that the denial of discovery was an appropriate exercise of discretion. *See, e.g., Scardelletti v. Debarr*, 43 Fed. Appx. 525, 528 (4th Cir. 2002) (unpublished opinion) ("The record demonstrates that the district court was adequately informed as to the factual basis for Devlin's conflict of interest and . . . did not abuse its discretion in declining to allow Devlin discovery."); *Kaus v. Standard Ins. Co.*, 1998 WL 778055, at *3 (10th Cir. 1998) (unpublished opinion) (plaintiff "failed to establish

that it would be appropriate to consider evidence outside of the administrative record" regarding an alleged conflict of interest).[4]

The Seventh Circuit's decision below is entirely consistent with the dicta and decisions from other circuits indicating that discovery into bias may be appropriate, but only in the proper factual circumstances. As the court of appeals explained, while discovery beyond the claims record normally is not allowed in "cases in which no evidence of a failure to conduct a 'genuine evaluation' has been presented," the situation is different when "a prima facie showing of bias or conflict of interest has been made." Pet. App. 15a. In the latter case, additional discovery may be appropriate:

> Although discovery is normally disfavored in the ERISA context, at times additional discovery is appropriate to ensure that plan administrators have not acted arbitrarily and that conflicts of interest have not contributed to an unjustifiable denial of benefits. . . . Where a claimant makes specific factual allegations of misconduct or bias in a plan administrator's review procedures, limited discovery is appropriate.

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[4] Petitioner cites three other decisions as conflicting with the decision below on the discovery standard, but these decisions are categorically inapplicable. Two of the decisions, *Tremain* and *Moon v. American Home Assurance Co.*, 888 F.2d 86 (11th Cir. 1989), involved cases of *de novo* review of an administrator's determination, and thus do not bear on this case, which involves discovery into bias when arbitrary and capricious review applies. In any event, both *Tremain* and *Moon* state that discovery may be appropriate in considering a conflict of interest, just as the Seventh Circuit did here. *Tremain*, 196 F.3d at 977; *Moon*, 888 F.2d at 89. Petitioner also cites *Kergosien v. Ocean Energy, Inc.*, 390 F.3d 346 (5th Cir. 2004), but that case holds that an *arbitrator* may go outside the administrative record in considering an alleged conflict of interest, 390 F.3d at 351-53; it offers no guidance on what discovery might be appropriate when a district court is reviewing a claim for benefits under ERISA § 502(a)(1)(B).

Id. at 17a. According to the decision below, discovery into bias is appropriate where the plaintiff (1) "identif[ies] a specific conflict of interest or instance of misconduct" and (2) "make[s] a prima facie showing that there is good cause to believe limited discovery will reveal a procedural defect in the plan administrator's decision." *Id.*

Applying that standard to the particular facts of this case, the court affirmed the district court's judgment that discovery into bias was not justified here. As the court explained, "the district court has significant discretion to allow or disallow discovery requests," but petitioner "ha[d] presented no prima facie evidence of misconduct or a conflict of interest" and thus was not entitled to discovery. *Id.* at 16a, 19a.

For the reasons explained, that factbound ruling raises no circuit conflict justifying review. While the merits of the Seventh Circuit's approach are thus largely beside the point, it bears noting that, contrary to petitioner's suggestion (Pet. 19), the flexible standard applied in the Seventh Circuit does not preclude plaintiffs from obtaining evidence needed to support genuine claims of bias or corruption. Petitioner herself admits that the Seventh Circuit does not bar discovery (*id.*); it simply requires a showing that discovery would be likely to produce relevant and admissible evidence of bias or corruption. Where, for example, the terms of the plan itself create a prima facie inference of bias, *see, e.g.*, *Pegram v. Herdrich*, 530 U.S. 211, 227 n.7 (2000) (citing example of plan providing "a bonus for administrators who denied benefits to every 10th beneficiary"), or it appears from the administrative record that the decisionmaker did not conduct a genuine evaluation, *see Perlman*, 195 F.3d at 982, a plaintiff might be entitled to discovery seeking to determine the extent to which bias or corruption affected the benefit determination. Indeed, district courts applying the Seventh Circuit's standard have allowed discovery to explore alleged conflicts of interest, *see, e.g.*, *Fowler v. Williams Cos.*, 2005 U.S.

Dist. Lexis 5025, at *6-7 (W.D. Wis. 2005), demonstrating the fairness and flexibility of the standard.

B. Petitioner's Claim For Benefits Would Fail Even If She Obtained The Relief Requested From This Court

Even if petitioner's Question Presented implicated any concrete legal controversies worthy of review by this Court, this case would be an inappropriate vehicle for resolving them, because any decision by this Court would have no effect on the ultimate disposition of the case. *See* Stern et al., *supra*, at 457 (case "presents a poor vehicle for resolving a conflict" where case "would be decided in favor of the respondent no matter how the conflict is resolved"). The most petitioner could possibly obtain through further review of this case is a remand order requiring the district court to apply a *de novo* review standard to the Plan's decision denying her claim to the second, extended LTD benefit provided under the Plan. Pet. 10 (seeking "plenary" court proceeding); *see also Firestone*, 489 U.S. at 115. The district court, however, has already stated explicitly that if the *de novo* review standard were applied here, "the denial of benefits would survive." Pet. App. 27a n.6. As the court explained, the medical evidence submitted by petitioner in support of her claim is "inconsistent at best and contradictory at worst, with some of her doctors even disagreeing with their own diagnoses in the space of as little as two weeks." *Id.* Given that weak showing plus the views of "both independent experts, who examined the medical evidence as a whole" and concluded that she could perform light or reduced work tasks, the court concluded that petitioner had not established a valid claim to the extended LTD benefit under the terms of the Plan. *Id.* Accordingly, any time and attention invested by this Court in answering the question petitioner presents for review will be literally wasted so far as the parties in this case are concerned.

While it is of course true that, as petitioner and her *amicus* state, employee benefits issues in general have broad social and economic significance, *see* Pet. 24; AARP Br. M-1, this case itself does not turn on any controversy in employee benefits law warranting certiorari review. Petitioner's underlying benefit claim lacks support in the factual record, and the arguments in her petition lack support in the legal precedents. There is no claim, case, or conflict here worthy of review by this Court.

CONCLUSION

For the foregoing reasons, the petition should be denied.

Respectfully submitted,

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